

MDR Tracking Number: M5-04-1385-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 01-15-04.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the office visits, therapeutic exercises, group therapy, and aquatic therapy rendered from 2/26/03 through 10/16/03 were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On March 29, 2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

**CPT Code 97113** for dates of service 4/7/03 through 4/14/03 was denied by the carrier with an "F"-fee guideline reduction and a partial payment of \$40.50 was made for those dates. According to the 1996 Medical Fee Guidelines, MAR for this code is \$52 per unit. Therefore, **additional reimbursement** in the amount of \$687.50 is recommended.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to dates of service 4/7/03 through 4/14/03 as outlined above in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Decision and Order is hereby issued this 4<sup>th</sup> day of October 2004.

Regina L. Cleave  
Medical Dispute Resolution Officer  
Medical Review Division  
RLC/rlc

March 12, 2004

Rosalinda Lopez  
Texas Workers' Compensation Commission  
Medical Dispute Resolution  
Fax: (512) 804-4868

Re: Medical Dispute Resolution  
MDR #: M5-04-1385-01  
IRO Certificate No.: IRO 5055

Dear Ms. Lopez:

\_\_\_ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, \_\_\_ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of \_\_\_ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine who is currently on the TWCC Approved Doctor List.

### **REVIEWER'S REPORT**

#### **Information Provided for Review:**

Correspondence  
History & physical exam and office notes  
Physical therapy notes  
Physical performance test/EMG reports  
Operative and Radiology reports

#### **Clinical History:**

This 35-year-old female twisted her right wrist and felt pain from the wrist to her shoulder while on her job on \_\_\_.

#### **Disputed Services:**

Office visits, therapeutic exercises, group therapy, and aquatic therapy during the period of 02/26/03 through 10/16/03.

#### **Decision:**

The reviewer agrees with the determination of the insurance carrier and is of the opinion that the treatment and services in dispute as stated above were not medically necessary in this case.

**Rationale:**

The TWCC Medical Fee Guidelines outline specific documentation requirements for medical necessity and the procedures billed. Guidelines listing criteria for determining which patients may benefit from passive or active care are not currently recognized in Texas by the Chiropractic Licensing Board, State Associations, or Practice and Parameters Committee. The general consensus is that candidates for active and passive therapy is a judgmental call determined by many possible variations of clinical presentations.

The Texas Worker's Compensation Commission Medical Fee Guidelines of 1996, which adopted its therapy guidelines from the Commission of Accreditation and Rehabilitation Facility [CARF] 1994 Standards Manual are the generally accepted guidelines.

In a document authored by K. D. Christiansen, D.C. entitled *Physical Therapy and Rehabilitation Guidelines For the Chiropractic Profession. Stage Four, the Rehabilitation Stage of Treatment Following 7-12 Weeks of Subacute Remodeling Phase*: "Each clinician must depend on his or her own knowledge of chiropractic and expertise in the use or modification of these materials and information. Generally, passive care is time limited progressing to active care and patient functional recovery."

The documentation presented for review [see above] failed to support the medical necessity of the above disputed treatment, services and therapy.

Sincerely,